

**DISABILITY DETERMINATION DATA/REPORT**  
**Medical Assistance Case**

**I. SOCIAL INFORMATION**

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Give social information based on applicant's statements, social worker's observations, and case narrative. Please be as specific as possible.

- A. Disabling condition or conditions: Describe, including cause, duration, response to treatment, etc.
- B. Effect of applicant's disability: Describe in terms of:
1. Mobility and limitation of ordinary physical activities:
  
  
  
  
  
  
  
  
  
  
  2. Dependence on others for help or service:
  
  
  
  
  
  
  
  
  
  
  3. Appliances or prostheses necessary (for example: hearing aid, crutches, artificial limb, etc.)
  
  
  
  
  
  
  
  
  
  
  4. Attitude and adjustment: (What can applicant do with remaining capacities?)
- C. Mental ability: Evaluate briefly from your observation, noting any unusual behavior and, if pertinent, include applicant's ability to read, write, handle finances, participate in interview, understand and follow directions, etc.

**I. SOCIAL INFORMATION (continued)**

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D. If currently employed, state in detail the type of work, the amount and kind of physical activity involved, the supervision required, and average monthly earnings and hours worked. Is the work subsidized, required by DCF, or sheltered?

E. Disability Benefits: Has the applicant ever filed for Social Security or Supplemental Security Income disability benefits?

			Date Filed	Date Claim Allowed	Date Claim Denied
OASDI:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____		

SSI:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____		
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Indicate any reason for denial of claim (or attach documentation of denial):

**II. MEDICAL HISTORY**

List the name, address and telephone number of  
the DOCTOR WHO HAS CLAIMANT'S MEDICAL RECORDS.

If claimant has no doctor,  
check here: \_\_\_\_\_

Name

Area Code and Telephone

Address (Street, City, State, Zip)

Reasons for Visits

Type of Treatment Received

B. Has claimant seen ANY OTHER DOCTOR since his illness or injury began?

\_\_\_\_ Yes

\_\_\_\_ No

No If "Yes," show the following:

Name

Area Code and Telephone Name

Address (Street, City, State, Zip)

How Often Does Claimant See Him?

Date Claimant First Saw Him?

Date Claimant Last Saw Him?

Reasons for Visits

Type of Treatment Received

If the claimant has seen OTHER DOCTORS since his illness began, list their names , addresses, dates and reasons for visits under "Remarks," Page 7.

C. Has claimant been HOSPITALIZED or treated at a CLINIC for his illness or injury?

\_\_\_\_ Yes

\_\_\_\_ No

Yes if "Yes," show the following:

Name of Hospital or Clinic

Patient or Clinic Number

Address (Street, City, State, Zip)

**II. MEDICAL HISTORY (continued)**

Was claimant an inpatient? (Stayed at least overnight)

Yes

No

If "Yes, Dates of Admissions: \_\_\_\_\_

Dates of Discharge: \_\_\_\_\_

Was claimant an Outpatient?

Yes

No

If "Yes, Dates of Visits: \_\_\_\_\_

Reason for Hospitalization or Clinic Visits

Type of Treatment Received

If claimant has been in other hospitals or clinics for his illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits under "Remarks," Page 7.

D. Has claimant been seen by OTHER AGENCIES for his injury or illness? (VA, Workmen's Compensation, Vocational Rehabilitation, Mental Health Center, State Institution, etc.)

Yes

No

If "Yes, show the following:

Name of Agency

Claim Number

Address (Street, City, Town, Zip)

Dates of Visits

Type of Treatment or Examination Received

**III. INFORMATION ABOUT YOUR EDUCATION**

A. What is the highest grade of school that you completed and when?

B. Have you gone to trade or vocational school or had any type of special training?

Yes

No

If "Yes," show:

The type of trade or vocational school or training

Approximate dates you attended

How the schooling or training was used in any work you did

**III. INFORMATION ABOUT THE WORK YOU DID (continued)**

List all jobs you have had in the past 15 years before you stopped working, beginning with your usual job. Normally, this will be the kind of work you did the longest. (If you have a 6th grade education or less and did only heavy unskilled labor for 35 years or more, list all of the jobs you have had since you began to work. If you need more space, list under "Remarks," Page 7.

JOB TITLE (Be sure to begin with your usual job.)	TYPE OF BUSINESS	DATES WORKED (Month and Year)		DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month, year)
		From	To		

Provide the following information for your usual job shown in Item A, Line 1.

In your job did you:

	Use machines, tools or equipment of any kind?	_____	Yes	_____	No
	Use technical knowledge or skills?	_____	Yes	_____	No
	Write material, complete reports, or perform similar duties?	_____	Yes	_____	No
	Have supervisory responsibilities?	_____	Yes	_____	No

C. Describe your basic duties (Explain what you did and how you did it.) below. Also, explain all "Yes" answers by giving a FULL DESCRIPTION of the types of machines, tools, or equipment you used and the exact operation you performed, the technical knowledge or skills involved, the type of writing you did, and the nature of any reports, and the number of people you supervised and the extent of your supervision.



#### IV. REMARKS

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See this section for additional space to answer any previous questions and to explain any other social factors which you feel should be considered in determining if disability exists.

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Social Worker

Date

Supervisor or Director